



PSYCHOLOGICAL SERVICES
Student Information Form

Name: Student ID: Date:

Address: (street number) (city) (zip code)

Phone: OK to leave a message on this phone? [ ] Yes [ ] No

Email: OK to send a message to this email? [ ] Yes [ ] No

Birth date: Age:

Emergency Contact: (Name/Relationship/Phone)

Gender: [ ] Male [ ] Female [ ] Transgender MTF / FTM [ ] Genderqueer [ ] Prefer not to answer

Sexual Orientation: [ ] Heterosexual [ ] LGBTQAIP please specify

Ethnicity: [ ] African American [ ] Asian/Pacific Islander (Specify) [ ] Caucasian [ ] Hispanic(Please Specify) [ ] Native American [ ] Other (Please Specify)

Background Information: [ ] International Student [ ] Veteran [ ] Homeless [ ] First Generation Student [ ] Work Part-Time [ ] Work Full-Time

Are you affiliated with these learning communities on campus? [ ] EOPS [ ] DSPS [ ] SSRS

Major: Expected graduation/transfer:

Medical conditions: Medications:

Reasons for seeking counseling:

- [ ] Anxiety, nervousness, worry [ ] Depression, sadness [ ] Anger, irritability, mood swings [ ] Loneliness, isolation, withdrawal [ ] Self-esteem, body image issues [ ] Concentration, memory [ ] Stress, trouble coping [ ] School/work problems [ ] Medical problems/concerns [ ] Grief, significant loss [ ] Problems with family [ ] Problems with friends [ ] Problems with partner [ ] Sexual abuse, rape [ ] Physical abuse [ ] Emotional abuse [ ] Harassment, stalking, threats [ ] Sexuality, coming out [ ] Cultural, religious conflict [ ] Internet/video game addiction [ ] Gambling [ ] Eating concerns [ ] Sleep concerns [ ] Financial problems [ ] Housing problems [ ] Legal problems [ ] Alcohol use [ ] Marijuana use [ ] Drug use [ ] Suicidal thoughts

Previous therapy or personal counseling experience: [ ] Yes [ ] No

When? How long?